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ABSTRACT

This document applies the Cognitive-Behavioral Approach to grief counseling and grief therapy. Although most people are able to work through their grief with support from family and friends, some people may not want to burden loved ones with their loss. Grief counseling or grief therapy is best used by those individuals who need the opportunity to talk confidentially and who want help while working through the stages of grief. Grief counseling emphasizes the need to increase the reality of loss, to help the client deal with expressed and latent affect and overcome various impediments to readjustment, and to encourage the client to make a healthy emotional withdrawal from the deceased and feel comfortable reinvesting in another relationship. Grief therapy, on the other hand, strives to identify and resolve conflicts of separation which preclude completion of the mourning tasks. Grief therapy is often used when a client fails to grieve or has trouble resolving feelings. It emphasizes the therapeutic goal of achieving emotional wellness after the loss of a significant other through the grieving process. Specific cognitive-behavioral techniques for both grief counseling and grief therapy are available. In grief therapy and grief counseling, there may be a tendency to overlook or disregard unconscious processes, view feelings as entities to be controlled, and have a judgmental differentiation between therapist and client. Therefore, cognitive-behavioral approaches to grief may not be well suited for all clients. (BHK)

Grief Counseling and Grief Therapy:

A Cognitive-Behavioral Perspective

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Abstract

From nearly the beginning of time death has been a "taboo" subject, shunned by society. Since death is an inevitable part of life, grief and bereavement eventually touch each of us at some time throughout the lifespan. Although most people are able to work through their grief with support from family and friends, some shrink from burdening loved ones with their loss. It is for these people, in need of both the opportunity to talk confidentially and assistance in working through the stages of grief, that grief counseling and/or grief therapy offered by trained mental health counselors, is essential to restoring emotional wellness. This paper focuses on taking a Cognitive-Behavioral approach (breaking from the traditional Gestalt and Client-Centered modes) to grief counseling and grief therapy. The therapeutic goal of achieving emotional wellness after the loss of a significant other and through the grieving process is emphasized throughout. Specific Cognitive-Behavioral techniques for both grief counseling and grief therapy are discussed.

Grief Counseling and Grief Therapy:
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Counseling professionals often share a common belief that cognitive-behavioral therapies grew out of traditional behavior therapy, which in turn was a break from the radical behavioral approach to human problems. In actuality, the cognitive-behavioral framework can be traced back to Stoic philosophers who believed: "[People] are disturbed not by events, but by the view they take of them" (Sank & Shaffer, 1984, p. 7). By maintaining such a stance [i.e., that human adjustment and maladjustment are often a reflection of underlying cognitive processes (Mahoney, 1980)], it is easy to see how the belief that changing how one thinks about the world became the major guiding force of cognitive-behavioral theory and therapy.

Basics of cognitive-behavioral therapy

What separates cognitive-behavioral therapies of today from other forms of therapy, particularly behavioral oriented therapy, is the incorporation of the mediational perspective (internal, covert processes called thinking or cognition occur and mediate the responses the individual has to his/her environment and the degree of adjustment or maladjustment of the individual) into the cognitive-behavioral approach to working with client problems (Dobson & Block, 1988). As a result of this mediational perspective, current cognitive-behavioral therapies share as their core three fundamental propositions:

1. Cognitive activity affects behavior;
2. Cognitive activity may be monitored and altered;
3. Desired behavior change may be affected through cognitive change (Dobson & Block, 1988).

With these three propositions as a theoretical base, cognitive-behavioral therapies, according to current literature (e.g., Freeman, 1983; Rose, 1989, Sank & Shaffer, 1984), focus on identifying how the individual develops ideas or cognitions about reality, how the individual chooses and decides from the many possibilities, and how the individual acts and behaves in relationship to reality.

A number of therapy approaches can be found within the cognitive-behavioral classification. Although these various approaches are operationally different, they share a common theoretical perspective that assumes: thinking or cognition occurs; cognitive events may mediate behavior change; behavioral change does not have to involve elaborate cognitive mechanisms (Dobson & Block, 1988). In addition, as Dobson and Block (1988) assert:

> "... because of the mediational hypotheses, not only is cognition able to alter behavior, but it must alter behavior, so that behavior change may thus be used as an indirect index of cognitive change" (p. 6).

Although outcomes of cognitive-behavioral therapy vary from client to client, in general, two common indices of client change are cognition and behavior.

To organize the array of existing cognitive-behavioral therapies, Mahoney & Arnkoff (1978) developed a classification system which separates therapies into three categories according to slightly different classes of change goals: Coping-Skills Therapies, Problem-Solving Therapies, and Cognitive Restructuring Methods. Coping-Skills therapies generally focus on helping the individual develop a repertoire of skill designed to assist them in coping with various stressful life situations. Successes within these therapies include reductions in the consequences of negative events and behavioral signs of better coping abilities or skills (Mahoney & Arnkoff, 1978). In Cognitive Restructuring Methods therapies it is assumed that the client's emotional distress is a consequence of maladaptive thoughts. A major index of client change within this category of therapies is the client's verbal reports of less dysfunctional thinking, assessed and validated with the client's behavior and mood (Mahoney & Arnkoff, 1978). Therapies included within the Problem-Solving Therapies category are characterized by a combination of cognitive restructuring techniques and coping-skills training procedures. Successes within these therapies include the development of general strategies for dealing with broader ranges of personal problems. It is within these three therapy

categories that the various cognitive-behavioral therapies fall.

As the above classification reveals, cognitive-behavioral therapies can be used in various modalities (both individual and group) with a multitude of client issues and concerns, including depression (Hollon & Beck, 1978; Kovacs, 1980; Morris & Beck, 1974; Rush & Beck, 1978), management of severe and chronic pain (Holroyd, Andrasik, & Westbrook, 1977), test anxiety (Holroyd, 1976), chronic anger (Novaco, 1976), stuttering (Moleski & Tosi, 1976), "irrational thinking" in the elderly (Keller, Croake, Brooking, 1975), and obesity (McNamara, 1989).

One area that appears to have "escaped the wrath" of the cognitive-behavioral influx is grief. To date, no study has reported on nor investigated the efficacy of using a cognitive-behavioral approach in grief counseling or grief therapy. This paper, therefore, examines a cognitive-behavioral approach to grief counseling and therapy.

Grief counseling vs grief therapy

Before beginning an exploration of cognitive-behavioral approaches to working with grief, a distinction needs to be made between two often confused procedures, grief counseling and grief therapy. According to Worden (1982) grief counseling involves helping people facilitate uncomplicated, or normal, grief to a healthy completion of the tasks of grieving within a "reasonable" time frame whereas grief therapy involves using special techniques to help people with abnormal or complicated grief

reactions. In this context, normal grief refers to uncomplicated grief, characterized by a broad range of feelings and behaviors that include, some type of somatic or bodily distress, preoccupation with the image of the deceased, guilt relating to the deceased or circumstances of the death, hostile reactions, inability to function as one had before the loss, and the development of traits of the deceased in ones own behavior (Lindemann, 1944). Although once thought of as maladaptive and disorganized, these feelings and behaviors are now viewed as normal reactions to the loss of a significant other.

Through uncomplicated grief, most people are able to cope with the grief reactions (described above) and work through the grieving on their own, thereby seeing grief to its conclusion. In contrast, some people, having experienced the loss of a significant other, have trouble resolving their feelings about the loss and find these unresolved feelings and issues hinder their ability to complete the grief tasks and thus resume a normal life. In cases of uncomplicated grief, grief counseling often helps bring grief to an effective conclusion. When grief has been hindered or has gone "wrong" (i.e., abnormal grief reactions) grief therapy is a more appropriate and therapeutic choice.

Throughout the grief literature, methods, techniques, and procedures are described mainly as originating from Gestalt and Client-Centered therapy perspectives. What follows is a

conceptualization of both grief counseling and grief therapy from a ccgnitive-behavioral perspective (i.e., the goals, procedures, and hopeful outcomes of each) and a general critique of the perspective as it applies to grief work. Although there are may types of grief counseling and grief therapy, this paper is only concerned with those forms which are offered by trained physicians, psychologists, mental health counselors, or social workers.

Grief counseling

As discussed above, the overall goal of grief counseling is to assist the client in completing any unfinished business with the deceased and to be able to say a final goodbye. In addition to this general goal, there are also specific goals which include: These specific goals include:

1. To increase the reality of the loss;
2. To help the client deal with both expressed and latent affect;
3. To help the client overcome various impediments to readjustment after the loss;
4. To encourage the client to make a healthy emotional withdrawal from the deceased and to feel comfortable reinvesting emotion in another relationship (Worden, 1982).

To make grief counseling effective, i.e., help the client work through an acute grief situation and come to a resolution,

certain principles and procedures should be utilized. These include: helping the client actualize the loss, helping the client to identify and express feelings, assisting client in living without the deceased, facilitating client's emotional withdrawal from the deceased, providing client time to grieve, interpreting client's "normal" behavior, allowing for individual differences between clients, providing client continued support, examining client's defenses and coping styles, and identify client's pathology and referring (Worden, 1982). Although various procedures can be used to work with these issues, cognitive-behavioral techniques can be used to facilitate movement and potential "change" within any of these areas.

In looking at the principles discussed above, particularly those of helping the client actualize the loss, interpret "normal" behavior, identify and express feelings, and examine defenses and coping styles, it appears that various techniques included within reality testing and cognitive restructuring would work well in helping clients realize these goals. One of the first tasks to be addressed is to help the client come to a more complete awareness that the loss actually has occurred, that the person is dead, and that the person will not return. The goal of this task, worked on by assessing the rationality of beliefs, would be the client's acceptance of the death reality so they are better able to move on to dealing with the emotional impact of the loss (Worden, 1982). As Parkes (1975) reports, one of the

most importance techniques in helping clients actualize the loss and begin to interpret "normal" behaviors is helping them talk about the loss. Throughout the process, the counselor can be a patient listener, encourage the client to continue talking about the loss, and help the client focus on and accept his/her helplessness in the circumstances surrounding the loss, thus helping him/her attribute the loss to external, uncontrollable causes (Seligman, 1975). By accepting a stance where he/she is not responsible for the loss, acceptance of the loss comes much more quickly (Worden, 1982).

Another cognitive-behavioral technique that can be useful in fulfilling the principles discussed above, particularly assisting the client in living without the deceased, is decision making. The process of assisting the client in living without the deceased involves helping him/her accommodate to the loss by facilitating his/her ability to live without the deceased and to make decisions independently (Worden, 1982). To do this, the counselor uses a cognitive-behavioral problem-solving approach where he/she examines what problems the client faces and how they can be solved in various ways. If these skills are new to the client (e.g., when a spouse dies and that spouse was the primary decision maker for the family) the counselor, in addition to teaching decision making skills, helps the client learn effective coping skills so he/she will be able to take over the decision-making role with less emotional distress.

In working though the principles discussed above, cognitive-behavioral methods can be used to facilitate a client's movement toward completed grief. In general, grief counseling begins, at the earliest, a week or so after the funeral, but there is no set rule (Worden, 1982). All depends on the circumstances of the death and the role of grief counseling.

Does grief counseling work? In a review of research studies Parkes (1975) concluded that professional services (psychiatrists and psychologists) greatly reduce the risk of psychiatric and psychosomatic disorder resulting from bereavement and acute grief reactions. Worden (1976), in a report of both empirical studies and clinical experience validates this conclusion regarding the effectiveness of grief counseling.

Grief therapy

When a client fails to grieve or has trouble resolving his/her feeling about the loss and finds unresolved feelings and issues hinder his/her ability to complete the grief tasks and resume a normal life, he/she may be experiencing complicated grief. Horowitz (1980) defines "problem grief" as:

> the intensification of grief to the level where the person is overwhelmed, resorts to maladaptive behavior, or remains interminably in the state of grief without progression of the mourning process toward completion ... [It] involves processes that do not move progressively toward assimilation or accommodation but, instead, lead to stereotyped

repetitions or extensive interruptions of healing (p. 1157). Today, more of a continuum exists between normal and abnormal grief reactions and between complicated and uncomplicated grief. In addition, pathology appears to be more related to the intensity or duration of a reaction rather than to the simple presence or absence of a specific behavior (Horowitz, 1980).

Whereas the goal of grief counseling is to facilitate the client's tasks of mourning so the bereavement process comes to a successful termination, the goal of grief therapy is to identify and resolve conflicts of separation which preclude completion of the mourning tasks particularly with clients whose grief is absent, delayed, excessive, or prolonged (Worden, 1982). According to Worden (1982) grief therapy is most appropriate and therapeutic in situations where: (1) the complicated grief reaction is manifested as prolonged grief; (2) the grief reaction manifests itself through some masked somatic or behavioral symptom; (3) the grief reaction is manifested by an exaggerated grief response.

Regardless of conflict origins, resolution requires the client to experience previously avoided thoughts and feelings (Melges & DeMaso, 1980). To achieve this, the therapist provides the social support necessary for successful grief work and works to "essentially" give the client permission to grieve, a permission which was most likely absent in the client's previous environment. This resolution can be achieved by first setting up

a behavioral contract and, then, using cognitive-behavioral methods of cognitive restructuring and self-management (Seligman, 1975), help the client examine the irrationality of his/her "permission" beliefs, and allow him/her to take control of himself/herself (internal locus of control) instead of giving that control to some external source (external locus of control). Although resistance is likely with these methods, it can be worked with as part of the therapy process. As numerous authors assert (e.g., Worden, 1982; Melges & DeMaso, 1980), grief therapy must be kept focused in this way for it to be effective and productive.

In addition to setting up a contract and examining beliefs for irrationalities, grief therapy includes reviving memories of the deceased, assessing incomplete grief tasks, dealing with affect or lack of affect stimulated by memories, exploring and defusing linking objects (i.e., symbolic objects the client keeps to provide a means for maintaining the relationship with the deceased), acknowledging the finality of the loss, dealing with fantasy of ending grieving, and finally, helping the client say a final goodbye (Worden, 1982). As with grief counseling, many cognitive-behavioral approaches, particularly cognitive restructuring, decision making, and self-monitoring, can be used to achieve the goals of grief therapy. Regardless of the method or technique used, as Worden (1982) states:

> Grief therapy works. Unlike some other

> psychotherapies, in which one may not be certain about the effectiveness and efficacy of the treatment, grief therapy can be very effective. The subjective experiences and observable behavioral changes lend credence to the value of such targeted therapeutic interventions (p. 77).

Evaluation

Although the application of cognitive-behavioral methods in grief counseling and grief therapy is rather new and has not, to date, been examined in the literature, they must still be evaluated on the same grounds as all other forms of cognitive-behavioral therapy. In general, aside from the usefulness and appropriateness of some cognitive-behavioral methods (particularly decision making strategies, reality testing, cognitive restructuring, and self-management) applying cognitive-behavioral applications in therapy can lead to a tendency to overlook or disregard unconscious processes, view feelings as "things" that "can" and "should" be controlled and not directly experienced, place a very excessive emphasis on rationality, and have a rather judgmental differentiation between therapist and client (Mahoney, 1980). With these weak points in mind it appears that cognitive-behavioral approaches to grief counseling and grief therapy might not be well suited for all clients with grief issues. Alternately, these clients might be better served, at least in some particular aspects, by approaches that emphasize expression of feelings. Given the "deep" nature

of grief it appears that the ideal therapeutic environment might well be a combination of both cognitive-behavioral methods and more expressive and feeling-oriented methods.

Although no one theoretical framework can be a panacea for all clients, the cognitive-behavioral framework has much to offer both those providing and those seeking assistance in working through grief.

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